

PETITIONER/PLAINTIFF:	CASE NUMBER:
RESPONDENT/DEFENDANT:	
EMPLOYER'S HEALTH INSURANCE RETURN	

1. Name of parent employee:

2. Home address of absent parent employee:
☐ Not known

3. ☐ The employee has *no* insurance policies for health care, vision care, or dental care through this employment.

4. ☐ The employee has the following insurance policies covering health care, vision care, and dental care:

<u>Company</u>	<u>Type of policy</u>	<u>Policy No.</u>	<u>Persons insured</u>
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Date:

(TYPE OR PRINT NAME OF EMPLOYER)	▶	(SIGNATURE OF EMPLOYER)
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Address:

Telephone No.:

5. Return this completed return to the following local child support agency within 30 days (*name and address of local child support agency*):

If any insurance coverage lapses, complete the notice below and return a copy to the same local child support agency.

NOTICE OF LAPSE IN HEALTH INSURANCE

6. The health insurance listed on the *Employer's Health Insurance Return* above has
☐ lapsed ☐ terminated **for (check one):**

a. ☐ all persons insured, for the following reason (*specify*):

b. ☐ the following person (*name*): _____ for the following reason (*specify*): _____

Date:

(TYPE OR PRINT NAME OF EMPLOYER)	▶	(SIGNATURE OF EMPLOYER)
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Address:

Telephone No.: